SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

Filing at a Glance

Company: National Health Insurance Company

Product Name: NH-1510-1/10-ABA-Application	SERFF Tr Num: NHIC-126430289	State: Arkansas
TOI: H15G Group Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed-Approved-Closed	State Tr Num: 44397
Sub-TOI: H15G.002 Large Group Only	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Banu Loyd	Disposition Date: 12/29/2009
	Date Submitted: 12/23/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2010		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Submitted as File and Use in Texas
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 12/29/2009	Explanation for Other Group Market Type:
	State Status Changed: 12/29/2009
Deemer Date:	Created By: Banu Loyd
Submitted By: Banu Loyd	Corresponding Filing Tracking Number:

Filing Description:

Honorable Jay Bradford
Commissioner of Insurance
Insurance Division
1200 West Third Street
Little Rock, AR 72201 1904

SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

RE: National Health Insurance Company
NAIC#: 4669-82538
Form No.: NH-1510-1/10 - Application

Dear Commissioner Bradford:

Enclosed for your review and approval is the above referenced form. This is a new form and is not intended to replace any existing form. The submitted form will be utilized with previously approved group hospital/surgical/medical policy form HSMPPO-2009P (SERFF Filing No. NHIC-126264594) and group hospital/surgical policy form USA+2002P (proof of prior approval attached).

This new application form is identical to previously filed application form NH-1175-8/09 (SERFF Filing No. NHIC-126264594) except for the benefit options in the box at the top right of page one, the removal of the eagle logo on page one, and the form number information at the bottom of each page. Application form number NH-1510-1/10 will be used in both paper and electronic format.

Since the content of this application form has been previously approved, we have entered a requested implementation date of 1/1/2010 which is the same as for the prior filing. If this is not acceptable, please advise and we will revise this date.

We certify that to the best of our knowledge and belief, this form does not violate any laws or regulations of your state and does not contain any previously disapproved provisions.

Thank you in advance for your time spent in the review of this filing. Please contact me if you should require any additional information.

Sincerely,

Eva A. Green, AIRC, FLMI, HIA
Vice President/Compliance Dept.
(817) 640-3410 - (817) 640-3465 fax
eva.green@nhic.com

Company and Contact

Filing Contact Information

Banu Loyd, Contract and Compliance Analyst banu.loyd@nhic.com

SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

P.O. Box 619999
Dallas, TX 75261-6199

817-640-1900 [Phone] 3748 [Ext]
817-640-3465 [FAX]

Filing Company Information

National Health Insurance Company	CoCode: 82538	State of Domicile: Texas
P.O. Box 619999	Group Code: 4669	Company Type: LAH
Dallas, TX 75261-6199	Group Name: Southwest Ins Partners	State ID Number:
(817) 640-1900 ext. 3410[Phone]	FEIN Number: 74-1541799	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	Same filing fee as home state of Texas.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Health Insurance Company	$100.00	12/23/2009	33053000

SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/29/2009	12/29/2009

SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 12/29/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Copy of Original Cover Letter USA+2002P	Approved-Closed	Yes
Form	Individual Application	Approved-Closed	Yes

SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/29/2009	NH-1510-1/10	Application/ Enrollment Form	Individual Application	Initial			NS2008_HSMPPO_NCApp_110V.pdf

APPLICATION FOR INSURANCE

SCHEDULE OF COVERAGE SELECTED
& PREMIUM PAID

HOSPITAL/SURGICAL/MEDICAL
(form USA+2002)
HOSPITAL/SURGICAL/MEDICAL PPO
(form HSMPPO-2009)

UNDERWRITTEN AND ADMINISTERED BY:
NATIONAL HEALTH INSURANCE COMPANY
HOME OFFICE —GRAND PRAIRIE, TEXAS

REQUESTED EFFECTIVE DATE:

_____

ELECTRONIC APPLICATION: O Yes O No

HOME OFFICE USE ONLY

I.D. NO._____

BASE PLAN O $ 2,500 O $ 3,500 O $ 5,000

DEDUCTIBLE: O $7,500 O $10,000

BENEFIT (CO-INSURANCE) PERCENTAGE OPTION :

O 100/0% O 75/25%

OUTPATIENT MEDICAL BENEFIT:

O $100,000 O $500,000

OUTPATIENT MEDICAL DEDUCTIBLE:

O $1,000 O $1,500 O $2,000 O $2,500 O $3,500

PPO O Yes O No NETWORK(S) _____

TOBACCO USER-APPLICANT: O Yes O No

TOBACCO USER-SPOUSE: O Yes O No

PAYMENT MODE: O Monthly O Quarterly O Semi-Annual O Annual

PAYMENT TYPE: O BANK-DRAFT O DIRECT O LIST BILL

References to "Spouse" in this Application include a domestic partner or a participant in a civil union if legally recognized in your state or jurisdiction of residence.

PRINT APPLICANTS' NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	Relation to APPL.	DATE OF BIRTH	AGE	P/S	FTS Y/N	BIRTH STATE	HEIGHT	WEIGHT	PREMIUM
1.			Appl.								
2.											
3.											
4.											
5.											

RESIDENT ADDRESS (Actual address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
MAILING ADDRESS (If different than Resident Address)	CITY	STATE	ZIP	COUNTY

BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP

HOME PHONE	BUSINESS PHONE	EMAIL

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:

APPLICANT:_____

SPOUSE:_____

TOTAL PREMIUM FOR BASE HOSPITAL/EOMB/SURGICAL PLAN (TOTALS FROM ABOVE) $_____

INITIAL SET-UP FEE, FIRST MONTH'S ASSOCIATION DUES AND A MONTHLY ADMINISTRATION FEE $_____

TOTAL INITIAL PAYMENT (INCLUDES PREMIUM, FEES, AND ASSOCIATION DUES) $_____

TOTAL DUE EACH PAYMENT THEREAFTER (FUTURE PAYMENTS INCLUDE MONTHLY DUES AND A MONTHLY ADMINISTRATION FEE) $_____

APPLICATION DATE	PRINT AGENT'S NAME (LAST, FIRST, MI)	AGENT'S NUMBER	PREMIUM	ASSOCIATION DUES	MONTHLY ADMIN. FEE

Statement Of Eligibility and Other Insurance

Applicant #1 must answer each question on behalf of each Applicant (any person to be covered). Please explain any "Yes" answer to questions 2-15 in the box at the bottom of the page

	YES	NO
1. Are all adult Applicants citizens of the United States? If "No", complete a Foreign Resident Questionnaire for each non-citizen-adult Applicant	○	○
2. Does any Applicant have any type of medical coverage now or within the past 90 days? Coverage includes but not limited to Individual, HMO, Employer-Group.	○	○
3. Will the coverage being applied for replace or change any coverage from another company?	○	○
4. Have you ever applied for coverage with National Health Ins. Co.? If issued, provide ID#	○	○
5. During the past 10 years, has any Applicant been declined medical, life or disability coverage or had such coverage rescinded? (MO residents need not answer this question.)	○	○
6. Does any Applicant participate in any hazardous sports or activities?	○	○
7. Has any Applicant ever been convicted of a felony or is anyone currently on probation?	○	○
8. Has any Applicant ever tested positive for HIV (Human Immunodeficiency Virus)? NOTE: (Residents of WI are not required to answer this question.)	○	○
9. In the past five (5) years has any Applicant been arrested for a DUI or DWI?	○	○
10. Has any Applicant ever tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○	○
11. Is any Applicant or household member-whether applying for coverage or not-currently pregnant or in the process of adopting a child? (If yes, please do not submit the Application)	○	○
During the past two (2) years has any Applicant:		
12. Used tobacco in any form including cigarettes, cigars, pipe or chewing tobacco?	○	○
13. Received disability income benefits, Worker's Compensation benefits, Social Security, or federal or state government aid such as Medicaid or Medicare, been bedridden or disabled, confined to or required the use of a wheelchair, walker, brace or crutch?	○	○
14. Received a prescription for or taken any prescribed medications? Name and reason?	○	○
15. Experienced more than a 20 pound unintentional weight loss, chronic or recurrent diarrhea, enlarged lymph glands and/or night sweats?	○	○

PLEASE PROVIDE DETAILS BELOW TO ANY "YES" RESPONSES TO QUESTIONS 2-15 ABOVE

Question #	Applicant #	Date	Explanation

Any question regarding diagnosis or treatment of a condition refers to diagnosis or treatment by a doctor or other health care professional.

Applicant #1 must answer each question on behalf of each Applicant (meaning any person to be covered). Answer either "Yes" or "No" to each part. If "Yes", please provide details for each "Yes" answer in the space provided at the bottom of the page.

16. HAS ANY APPLICANT EVER HAD SYMPTOMS OF, BEEN DIAGNOSED WITH, OR RECEIVED TREATMENT FOR:

	YES	NO
(a) Chest pain, heart murmur, mitral valve prolapse, hypertension, high blood pressure, cholesterol, heart attack, stroke, angioplasty/bypass, stent placement or any other disease or disorder of the heart or circulatory system?	○	○
(b) Anemia, lymphoma, leukemia, connective tissue disease, phlebitis, embolism or any other disease or disorder of the blood, spleen or immune system?	○	○
(c) Asthma, bronchitis, pneumonia, allergies, chronic obstructive pulmonary disease, emphysema, sleep apnea or any other disease or disorder of the respiratory system?	○	○
(d) Ulcer or stomach disorder, colitis, diverticulitis, reflux, ileitis, rectal disorder, hemorrhoids, hernia, or any other disease or disorder of the gastrointestinal system?	○	○
(e) Pancreatitis, gall stones, hepatitis, cirrhosis, or any other disease or disorder of the biliary system or liver?	○	○
(f) Prostatitis, elevated PSA, kidney stones, kidney or bladder disease, nephritis, blood or sugar in the urine or any other disease or disorder of the urinary tract or male reproductive system?	○	○
(g) Breast disorder, lump or breast-implants, endometriosis, pelvic pain, abnormal pap, infertility, a Cesarean Section delivery, Pelvic Inflammatory Disease, or any other disease or disorder of the female reproductive organs?	○	○
(h) Epilepsy or seizures, convulsions, headaches, fainting, dizziness, brain disorder, spinal cord disorder, nervous disorder, paralysis, developmental delay, autism or any other disease or disorder of the nervous system?	○	○
(i) Arthritis in any form, rheumatism, gout, fibromyalgia, osteoporosis, or any other disease or disorder of the bones, joints, muscles, spine (including scoliosis), or back, hip or knees?	○	○
(j) Polyp, cyst, cancer, tumor, dysplasia or abnormal growth whether benign or malignant?	○	○
(k) Herpes, syphilis, and/or any other sexually transmitted disease or disorder?	○	○
(l) Cataract, glaucoma, or any other disease or disorder of the eyes or ears-including tubes, nose, throat or skin?	○	○
(m) Goiter, thyroid, pituitary or adrenal gland, diabetes, abnormal blood sugar or any other disease or disorder of the endocrine system?	○	○
(n) Mental, nervous or emotional disorder; anxiety or depression, alcohol use, dependency or addiction; drug or chemical use, dependency or addiction; eating disorders?	○	○

17. In the last five (5) years, has any Applicant had any medical or surgical advice, treatment or operations other than as indicated above or been advised to have medical tests or surgery that has not yet been performed, or is awaiting medical test results? ..... ○ YES ○ NO

IF ANY ANSWER TO ANY PART OF QUESTION 16 OR TO QUESTION 17 IS "YES" FOR ANY PERSON TO BE INSURED, PROVIDE DETAILS BELOW:

Applicant #	Nature of Illness or Accident Include Diagnosis, Operations & Medications	Date Started	Date Ended	Surgery?	Hospitalized From/To	Physician's Name, Address & Phone #

18. FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS.
(Attach extra page if more space is needed)

APPLICANT #1'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP

The following statements must be reviewed carefully and signed as indicated:

"I understand that no benefits are payable for a Pre-Existing Sickness or Injury until the Insured has been covered for twenty-four (24) months under the Group Policy. Variations in this Pre-Existing Condition provision due to specific state mandates will be explained by a separate Disclosure Notice* and any exclusionary riders will be explained at the time coverage is issued.
I understand the waiting period for Pre-Existing Conditions."
*Applies to SC, TX, and other states.

SIGNATURE OF APPLICANT #1 (FOR AND ON BEHALF OF ALL APPLICANTS):

X_____

"I hereby apply to National Health Insurance Company for coverage under a Certificate to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Certificate and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Group Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein. I acknowledge receipt/review of the Medical Information Bureau Pre-notice, Summary of Coverage, and Disclosure Notice."

DATED AT: CITY	STATE	MONTH	DAY	YEAR

SIGNATURE OF APPLICANT #1 (FOR AND ON BEHALF OF ALL APPLICANTS)	SIGNATURE OF SPOUSE, PARENT (If MINOR), NEXT OF KIN OR LEGAL REPRESENTATIVE
X_____	X_____

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and which may subject such person to criminal and/or civil penalties.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? ..... O Yes O No
2. Did you personally meet with each Applicant? (If No explain) _____ O Yes O No
3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all the family members..... O Yes O No
4. I have left or made available a Summary of Coverage and a Disclosure Notice. ..... O Yes O No
5. Was the application solicited by: ..... O Paper O Electronic
6. Mail certificate to: ..... O Agent O Insured

AGENT NAME (PLEASE PRINT FIRST AND LAST NAME)	ADDRESS	CITY	STATE	ZIP

SIGNATURE OF AGENT	AGENT NUMBER	MONTH	DAY	YEAR
X_____				

SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %
1.		
2.		
3.		

SERFF Tracking Number:	*NHIC-126430289*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*44397*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NH-1510-1/10-ABA-Application*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/29/2009

Comments:

The Flesch Certification and the Consumer Information Notice are N/A since this is an application only filing.

We have attached the required Certification of Compliance form below.

Attachment:

AR-Certification of Compliance.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	12/29/2009
Bypass Reason:	This is an application only filing - see Forms tab.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Copy of Original Cover Letter USA+2002P	Approved-Closed	12/29/2009

Comments:

Copy of original approval for policy form USA+2002P.

Attachment:

Original Cover Ltr USA+2002P_Approval.pdf

State of Arkansas

C E R T I F I C A T I O N

National Health Insurance Company

Policy Form: NH-1510-1/10 - Individual Application

I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify that they are in compliance with the applicable statutes, regulations, and bulletins of the State of Arkansas.

12/23/09

Date

Signature

Charles W. Harris
President
Name and Title of Officer

AR FF4

NATIONAL HEALTH INSURANCE COMPANY

November 30, 2001

OVERNIGHT MAIL

Honorable Mike Pickens
Commissioner of Insurance
Insurance Division
1200 West Third Street
Little Rock, AR 72201-1904

RECEIVED
DEC - 3 2001
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

ATTN: John Shields
Director, Life & Health

RE: **National Health Insurance Company**
NAIC#: 1315-82538
Policy Form No.: USA+2002P - Group Hospital Surgical Policy
Certificate Form No.: USA+2002 - Group Hospital Surgical Certificate
Rider Form No.: NH-IVMBR-2002(AR) - Optional In Vitro Fertilization Maternity Benefit Rider
Rider Form No.: NH-DBR-2002 - Optional Dental Benefits Rider
Rider Form No.: NH-PDR-2002 - Optional Prescription Drug Benefit Rider
Application Form No.: NH-1175-1/2
Supplement to Application Form No.: NH-1161-7/1

APPROVED
DEC 10 2001
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Dear Mr. Shields:

Enclosed for your review and approval are the above referenced forms. These are new forms and are not intended to replace any existing forms.

Policy form USA+2002P is a group hospital surgical plan which is issued to the United Service Association For Health Care, sitused in the District of Columbia. Coverage under the group policy is evidenced by the Certificate of Insurance, USA+2002, to be issued to members of the Association. This product will be solicited by licensed agents using application forms, NH-1175-1/2 and NH-1161-7/1. This product will not be mass marketed. This product will not be marketed to "Small Employers" as that term is defined in your state or under federal law.

The Optional Dental, Maternity, and Prescription Drug Benefit Riders are optional benefit riders that may be selected by the applicant. Additionally, please note that application form number NH-1175-1/2 is also an application for group term life insurance coverage under group policy form NH-LTL-P01 which has been previously approved by your office (proof of approval is enclosed for your reference).

Additionally, enclosed is a rejection form signed by the group policyholder which applies to various Arkansas mandated offers of coverage.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. Following are the Flesch scores for the submitted forms:

Policy/Certificate Form USA+2002	50.64
NH-IVMBR-2002(AR) - Optional In Vitro Fertilization Maternity Benefit Rider	52.41
NH-DBR-2002 - Optional Dental Benefits Rider	53.50
NH-PDR-2002 - Optional Prescription Drug Benefit Rider	45.95

Your early review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at our toll-free number 1-800-237-1900, extension 3748.

Sincerely,

Banu Loyd

REC'D S & C DEPT.
DEC 11 2001

Ms. Banu Loyd
Contract and Compliance Analyst
banu.loyd@nhic.com